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December 1, 2008

MEMORANDUM

TO:
Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Tara Larson
Leza Wainwright

SUBJECT: Implementation Update #51
Rate Reduction for TCM
DMA Procedures for NEA Withdrawal
Reinstatement of Provider Numbers
Reporting a Change in Provider Status
ValueOptions Updates
START Teams and Crisis Respite
CAP-MR/DD Update
PCP Form & Manual Revisions
Provisionally Licensed Assessments

Rate Reduction for Targeted Case Management

On October 10th, the Division of Medical Assistance (DMA) issued notice of a rate reduction for Targeted Case Management (H1017 HI) effective January 1, 2009 to $14.59. As we explained in the October 10th memo, we are faced with establishing a rate that is consistent with the methodology mandated by the Center for Medicare and Medicaid Services (CMS) guidelines and ultimately obtaining CMS approval for a long outstanding State Plan Amendment. We also recognize the critical timing of this rate activity as we implement the CAP-MR/DD waiver changes and other changes in the Medicaid program.

In order to balance the need for compliance, ensure that we have a rate setting methodology that meets CMS guidelines and represents an equitable payment for services, we will be implementing the following process:

- The DMA staff will collaborate with a representative group of providers identified to review CMS guidelines, review actual cost data, supporting documentation and justification for a final proposed TCM rate.

- The work group identified will work over a period that will not extend past November 30, 2008, to develop a new proposed rate that once approved by the North Carolina Department of Health and Human Services (DHHS) will be submitted to CMS for final approval.
- For the period from the date of this letter through **December 31, 2008**, DMA will continue to pay claims at the current rate of $**22.16 per 15 minute** unit of service.
- Beginning **January 1, 2009 and continuing until February 28th, 2009**, unless otherwise required by CMS, DMA will pay claims at the rate of **$18.75 per 15 minute unit** of service. If CMS requires or denies the rate change, DMA will follow the requirements of CMS.
- Beginning **March 1, 2009 and thereafter**, DMA will pay claims at the lower of the rate approved by DHHS or the rate approved by CMS, based upon the effective date of the CMS approval of the State Plan Amendment.

Please direct any questions you might have concerning this information to Steve Owen, Chief Business Operating Officer at steve.owen@ncmail.net or 919-855-4123, or Roger Barnes, Assistant Director of Finance Management at roger.barnes.dma@ncmail.net or 919-855-4190.

DMA Procedures for Processing Notification of Endorsement Action for Withdrawn Endorsement

Notifications of endorsement action (NEA) withdrawal letters are received at DMA Provider Services by certified mail or by email at endorsement.DMA@ncmail.net (only NEAs for withdrawn endorsement are to be emailed). Per the direction of Implementation Update #49, the NEAs are not to be submitted to DMA until the provider's appeal rights with the Local Management Entity (LME) have been processed or timeframe for request of reconsideration has expired.

NEA withdrawal letters are screened and calls are made to the LMEs requesting corrected copies for those which are found to be incomplete or incorrect. Examples of common errors are:

- Listing multiple provider numbers or provider types on a single NEA
- No explanation for the withdrawal on page two in the comments section (this vital information is required for DMA reporting requirements)
- Failure to use the approved NEA template

When a NEA withdrawal letter is processed by DMA Provider Services, a certified letter is sent to the provider advising the provider of receipt of the NEA withdrawal and informing them they are no longer permitted to deliver or bill for the withdrawn services.

Upon notification by DMA the provider has the right to appeal the action by the LME. Appeal rights are explained in the termination letter. Providers of Community Intervention Services *other than* Community Support have fifteen business days from the date of the termination letter to request a reconsideration of the provider number termination by the State MH/DD/SA Appeals Panel. To request a reconsideration review, the provider must submit a request in writing to the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, 3001 Mail Service Center, Raleigh, NC 27699-3001. A provider may appeal the decision of the State MH/DD/SA Appeals Panel by filing a formal appeal with the Office of Administrative Hearings (OAH). At the discretion of the Secretary of the Department of Health and Human Services, the requirement that the provider first appeal to the State MH/DD/SA Appeals Panel prior to filing a contested case with OAH may be waived. Providers wishing to file an appeal at OAH must submit a contested case petition form, which is available from the DHHS Hearing Office at (919) 647-8200 or 1-800-662-7030. Or, the provider can call the Office of Administrative Hearings directly at (919) 733-2698. The provider must mail the contested case petition form both to the Office of Administrative Hearings, 6714 Mail Service Center, Raleigh, NC 27699-6714 and the Office of Legal Counsel, NC Department of Health and Human Services, 101 Blair Drive, Raleigh, NC 27603.

Providers of Community Support services have unique appeal rights. These providers must file a Community Support Provider Petition within 30 days of the date of the termination letter. Copies of the form can be obtained by calling the DHHS Hearing Office at (919) 647-8200 or at:
http://www.dhhs.state.nc.us/mhddsas/stateplanimplementation/providerendorse/cssprovidercontestedcaseform-0908.doc.

Instructions for filing the appeal are on the petition. Appeal rights are set forth in Section 10.15A.(e2) of S.L. 2007-107. Community Support provider payments are suspended during the appeal process.

Reinstatement of Provider Numbers

A lapse in endorsement will require a new application for reinstatement. The provider will not be eligible to bill for services during any period an endorsement is not in place. The two circumstances under which a Community Intervention Service provider number can be reinstated without having to submit a new enrollment application are:

- If a provider prevails in an appeal
- When DMA acts on an NEA for withdrawn endorsement that has been antiquated by the issuance of a more current NEA which indicates the provider is validly endorsed, provided there is no lapse of endorsement.

Reporting a Change in Provider Status

All providers are responsible for ensuring that information on file with the North Carolina Medicaid Program for their practice or facility remains up to date. Providers are responsible for notifying DMA when information related to their business or practice changes. This includes changes of ownership (within 30 days), name, address, telephone number, electronic mail address, tax identification number, licensure status, and the addition or deletion of group members.

How a change is reported to DMA depends on the type of change that is being reported. All forms must be signed by the individual provider or for a group, the authorized agent.

- Changes submitted using the **Medicaid Provider Change Form** may be submitted by **mail or fax.**
- Changes that require the submittal of a new **Provider Enrollment Packet, Enrollment Addendum, or new Provider Participation Agreement** must be submitted by **mail** because an original signature is required.

For more information regarding reporting a change to Medicaid, visit http://www.dhhs.state.nc.us/dma/provider/changematrix.htm.

ValueOptions Updates: One Request per Fax Transmission

Please submit one request per fax transmission to ValueOptions. Do not include multiple requests for the same consumer or requests for multiple consumers in the same fax transmission. Submitting one request per fax:

- Increases the accuracy and speed of handling for your request
- Eliminates the need for non-routine handling of the request
- Decreases the risk of misdirected requests

In addition, faxing only one request per transmission will provide a relevant fax confirmation as proof of submission.

Receive ValueOptions Fax Confirmations

Fax confirmation sheets are required as proof of a previous fax submission. Providers can receive a fax confirmation sheet from the ValueOptions fax server once they set up the Caller/Sender Identification (CS ID) on their fax machine. Consult the fax machine's user guide or scroll through the machine's menu to set up the CS ID.

New Registration Process for ProviderConnect Training

The registration process for ProviderConnect training has been modified to simplify registration and accommodate the increased volume of requests for training. Go to www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm and scroll down to "Provider Training Opportunities" to view the upcoming webinar schedule and register for a particular date. The webpage will be updated with additional training dates and topics.

START Teams and Crisis Respite Beds

Each of the three regions of the state now has two START teams. In September 2008, the DMH/DD/SAS awarded funds to a lead LME in each region to establish two clinical START teams and one four-bed crisis respite facility.

Region	LME	Providers
Eastern	East Carolina Behavioral Health LME	RHA, Inc.
Central	The Durham Center	Easter Seals/UCP
Western	Western Highlands Network LME	RHA, Inc.

DMH/DD/SAS selected lead LMEs and providers of START teams and crisis respite beds as a result of a collaborative process led by Joan Beasley, Ph.D., founder of the program. LMEs and providers that expressed interest in this program participated in the process.

What Is START?

A Systemic/Therapeutic/Assessment/Respite/Treatment team, better known as **START,** is a national model of crisis prevention and intervention supports and services. START is designed for individuals with intellectual and/or developmental disabilities and behavioral healthcare needs. START is designed to help prevent unnecessary hospitalizations, promotes transitions to the community from state developmental centers, and keeps individuals in their communities.

START teams help families and providers twenty-four hours a day, seven days a week. At the request of a provider or family, and often working with a mobile crisis team, a START team evaluates a person in crisis. The START team provides immediate crisis care and arranges clinical and emergency meetings to plan ongoing treatment. START teams consult with and train community providers and others such as hospital staff. The teams help develop collaboration across disciplines and coordinate services for high risk individuals.

Who Staffs a START Team?

The START teams consist of a team leader and two masters or bachelor level qualified professional team members. The teams have access to ongoing psychology and psychiatry consultation.

How Does Crisis Respite Help?

Crisis respite provides direct intervention and clinical services to a person at a location usually away from the person's home. Respite care also provides relief for the family or primary caregiver. A master's level respite director oversees respite staff and ensures 24 hour awake staff. Two beds are reserved for planned respite (up to 72 hours) and two are for crisis respite (up to 30 days). The START team is actively involved during all respite stays.

CAP-MR/DD Update

The following information is intended to provide clarification.

Participant Movement into New Waivers

DMH/DD/SAS has been working with LMEs to transition existing participants into the two new CAP-MR/DD waivers
based on annual cost summary totals. Participants whose annual cost summary total is less than $17,500 dollars were placed in the Supports Waiver. Participants whose annual cost summary was $17,501-$135, 000 were placed into the Comprehensive Waiver. DMH/DD/SAS is confident that we have transitioned a high percentage of participants into the two waivers and need to come to closure on this process. It is the responsibility of the DD Coordinator at the LME to confirm the submitted information is final by notifying Tara Heasley at 919-715-2774 or tara.heasley@ncmail.net no later than **December 15, 2008.**

Home Supports

Home Supports is a service that may be delivered by biological parents, adoptive parents, step-parents, guardians of the person and other family members who live in the natural home with the participant. Home

Supports is not intended for individuals who live in "out of home" placements. Examples of "out of home" placements include group homes, foster care homes and Alternative Family Living (AFL) settings. Even in instances where the guardian may live in the AFL setting with the participant they are not eligible to receive Home Supports. In this setting it may be appropriate for the participant to receive Residential Supports, based on the needs of the individual participant.

Day Supports and Personal Care Services
The service Day Supports is provided in licensed Day Programs. The Day Supports service allows for the occasional assistance to participants with personal care needs. The provision of Personal Care Service cannot be provided at the Day Program. There will be no exceptions for the provision of Personal Care Services in the Day Program setting.

Supervision of Paraprofessionals
The new waivers require the services delivered by paraprofessionals to be performed under the supervision of a Qualified Professional (QP). Associate Professional staff may provide administrative supervision for paraprofessionals – scheduling, leave approval and timekeeping, monitoring compliance with requirements for training, etc. – but the actual services and supports delivered by the paraprofessional must be supervised by the QP.

Health and Safety Checklist
As noted in Implementation Update (IU) # 49, each LME is responsible for completion of the Health and Safety Checklist for unlicensed Alternative Family Living homes, where participants are receiving Residential Supports services. This requirement is a part of the LME monitoring process, and is a continuing requirement, although, it is no longer necessary to submit the completed checklist to DMA or DMH/DD/SAS. The LMEs should maintain the completed checklists in their files. This monitoring is to be completed annually.

If in the completion of the monitoring there are potential health/safety concerns the LME is to act to ensure the participant is residing in a safe setting. With matters noted within the checklist as a deficit, the LME is responsible to follow internal policy in notifying the provider agency to submit to the LME a plan of correction, according to LME policy. All actions are subject to LME policy and process. The document is posted on the CAP-MR/DD page http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm

First Aid and CPR Requirements
Per the service definitions contained in the new CAP-MR/DD waivers, staff must successfully complete First Aid and CPR training**.** This means staff must be "certified" in First Aid and CPR, therefore staff must provide a copy of the certificate from approved First Aid and CPR trainers. Provider staff shall keep this documentation on file for review by LMEs and regulatory agencies.

CAP Monitoring Procedure and Acknowledgement Letter
Attached are two documents (*CAP Monitoring Procedure* and the *Acknowledgment Letter)* for use by LMEs and providers with regard to existing providers of the eight modified services and existing providers who signed the Attestation Letter for Home Supports. This is an effort to provide guidance and standardization for this monitoring activity.

Person Centered Plan Form and Instruction Manual Revisions
Since the implementation of the Person Centered Plan (PCP) in 2006, the DMH/DD/SAS has received extensive feedback from stakeholders. The DMH/DD/SAS has taken into consideration this feedback in conjunction with recent legislative requirements to publish a **comprehensive** revision of the Person Centered Plan and Instruction Manual. The revised documents will have an effective implementation date of January 1, 2009; this means that any PCP annual review that is due in January of 2009 will need to be updated on the new forms. Revisions will not be subject to the new forms, only the annual plan. Please also note that this same plan will be utilized by CAP-MR/DD recipients; however, the implementation for those recipients will be due at a later date to be announced in a future update by DMH/DD/SAS. The comprehensive revision of the Person Centered Plan and Instruction Manual will be available on the DMH/DD/SAS website December 1, 2008 at: http://www.ncdhhs.gov/mhddsas/pcp.htm.

Changes include requirements defined in House Bill 2436, SECTION 10.15.(w) which stipulates that the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services develop a service authorization process. Requirements for the authorization process include the following:

- A comprehensive clinical assessment completed by a licensed clinician prior to service delivery (except when this requirement would impede access to crisis or other emergency services).
- The licensed professional that signs a medical order for behavioral health services must indicate on the order whether the licensed professional has had direct contact with the consumer, and has reviewed the consumer's assessment. (Note: Failure to comply dictates that the Department report to the licensed professional's occupational licensing board.)

There has been an on-going need for a training program for person-centered planning, the required forms, and the instruction manual. DMH/DD/SAS is excited to announce it has developed a web-based curriculum which is designed to:

- Meet the three hour training requirement for "PCP Instructional Elements" (referenced in IU #36)
- Facilitate and enhance awareness of person-centered planning philosophy
- Detail basic activities/processes involved in completing the person-centered plan forms
- Provide various links and downloadable resources

The web-based training curriculum will be available by mid December via a link on the Person Centeredness DMH/DD/SAS website: http://www.ncdhhs.gov/mhddsas/pcp.htm.

Provisionally Licensed Professionals Performing Assessments

The question has been raised concerning how or if a provisionally licensed professional can provide assessment and diagnosis. Currently, there are two ways that the assessment is being provided.

The first is through the use of a formal Diagnostic Assessment. The details of this method are found in the service definition for Diagnostic Assessment. This service definition does not include the use of provisionally licensed professionals as among the staff able to perform this service.

The second method of performing the assessment is through a comprehensive clinical assessment. Guidance pertaining to the requirements of this assessment may be found in the Records Management and Documentation Manual (section 5.2). The comprehensive clinical assessment should be performed by licensed individuals. An exception would be the use of the Incident To policy (see Implementation Update # 43). If a physician chooses to have a provisionally licensed clinician bill under their Medicaid ID number using the Incident To policy, then the provisionally licensed person could perform the assessment and the physician would bill the appropriate H code(s) under their physician's Medicaid ID number.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

cc: Secretary Dempsey Benton
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